

Drug Medi-Cal Organized Delivery System (ODS) Benefits

Service	Required	Optional
Outpatient Services	ODF & IOT	Partial Hospitalization
Residential Services	At Least 1 Level of Service	Additional ASAM Levels
Withdrawal Management	At Least 1 Level of Service	Additional ASAM Levels
Medication Assisted Tx	Yes	
Recovery Services	Yes	
Case Management	Yes	
Physician Consultation		Yes

County Responsibilities

Selective Contracting

- ▶ However, must maintain client access to services.
- ▶ Must provide a continuum of care with the required services.
- ▶ Must have policies & procedures for selection, retention, credentialing and re-credentialing.

County Responsibilities

- ▶ Authorization of Residential Services
- ▶ State–County contract with further detailed requirements for access, monitoring, appeals, etc.
- ▶ Beneficiary access number
- ▶ Coordination – MOU – with managed care plans.

County Responsibilities

County Implementation Plan

- ▶ County implementation plans must ensure that providers are appropriately certified for the services contracted, implementing *at least two evidence based practices*, trained in ASAM Criteria, and *participating in efforts to promote culturally competent service delivery*.

County Responsibilities

Coordination with DMC-ODS Providers

- ▶ Culturally competent services
- ▶ Medication Assisted Treatment
- ▶ Evidence based practices
 - Evidence based programs – Matrix, Seeking Safety
 - Evidence based counseling methods and techniques – CBT, MI, etc.

Top 5 Challenges in Expanding Capacity

▶ Outpatient

1. Reimbursement rates
2. Facility certification
3. Regulatory requirements (e.g., documentation)
4. Space
5. High upfront investment required/financial risk

▶ Residential*

1. Reimbursement rates
2. High upfront investment required/financial risk
3. Facility certification
4. Space
5. Staff certification/licensing

▶ IOP

1. Facility certification
2. Reimbursement rates
3. Regulatory requirements (e.g., documentation)
4. Space
5. High upfront investment required/financial risk

▶ NTP

1. Facility certification
2. Community opposition (i.e., NIMBY)
3. Staff certification/licensing
4. High upfront investment required/financial risk
5. Regulatory requirements (e.g., documentation)

• Detox

1. Reimbursement rates
2. Space
3. Facility certification
4. High upfront investment required/financial risk
5. Staff certification/licensing

* 49% rated RESIDENTIAL as the MOST CHALLENGING modality to expand.

Highest Priority Training Areas

1. ASAM assessment and placement
2. Utilization management
3. DMC billing for services

County Implementation Plan

Sections in the Plan:

- ▶ Narrative
 - Service Delivery System
 - Quality Assurance Activities
 - Integration of Services

- ▶ Assurances
 - Assure beneficiary access to all covered services.

- ▶ Projected Beneficiaries
 - Projections for each service modality
 - Projections for each level of service

Implementation Plan (cont.)

- ▶ Proposed Rates
 - Proposed rates for each service modality
 - Rates would correlate with utilization projections
 - Brief narrative would justify the rates.
- ▶ The County Behavioral Health Director must review and approve the Implementation Plan. Board of Supervisors approval is optional.
- ▶ Rates must also be approved by DHCS and CMS.

DMC-ODS County Fiscal Plan

- ▶ Counties are required to submit an annual County Fiscal Plan for the continuum of care identified in the DMC-ODS. DHCS will review and approve the Annual Fiscal Plan as a part of the overall approval to participate in the DMC-ODS.
- ▶ The projected expenditures must be calculated as full funds expenditures including both federal and matching local funds. The total projected expenditures should be calculated consistent with federal Medicaid requirements related to administration, indirect and direct service costs and interim payment and cost settlement requirements.

DMC-ODS County Fiscal Plan

- ▶ Projected units of service should include the total covered service utilization estimate for each modality for the fiscal year indicated.
- ▶ Projected Medi-Cal beneficiaries include all beneficiaries who will be served for each modality of service. This count will not be a unique client count. For example, if one beneficiary is projected to receive residential and Opioid (Narcotic) Treatment services, the beneficiary will be included in both modalities on the chart.
- ▶ ASAM levels 3.7 and 4 for Residential and Withdrawal Management are paid for through the fee-for-service system. Counties will not fund these services through the DMC-ODS system. However, DHCS would like projected client counts for these modalities.

Fiscal Provisions

Rates

- Rates are set at the State rates; however, counties can propose coming in higher or lower, except for NTP services.
- If counties propose a rate different than the current rate, there can be a geographic variation in the proposed rate.
- Counties will need to explain in their implementation plans why the proposed rate is higher or lower than the State rate.
- The State will negotiate the proposed rates with the counties and will have final approval.

DMC-ODS County Fiscal Plan

- ▶ Proposed rates must be developed for each required and, if indicated, optional service modality. The proposed rates must be developed consistent with the terms and conditions of the waiver, written guidance provided by the department and federal certified public expenditure requirements related to interim payments, and annual reconciliation and settlement. Counties will outline the proposed interim rate setting methodology used for each modality including the sources of information utilized such as previous years filed cost reports, approved medical inflation factors and any other sources used consistent with guidance related to federal health care programs.

Other Factors to Consider

- ▶ ***Workforce requirements:***

Counties should consider competitive salaries at all staff levels – i.e. recovery specialists, counselors, clinicians, clinical supervisors and management personnel –in development of service rates and cost estimates.

- ▶ ***Achieving Residential Level of Care ASAM Criteria:***

All residential providers must be certified to meet up to three ASAM level of care and receive a DHCS issued ASAM designation for each level of care. Meeting such standards will require an expansion of the current workforce and an increase in professional staff. In addition, all current and newly hired staff will need to be trained on the ASAM criteria.

Other Factors to Consider

- ▶ *Determination of Medicaid eligibility ,Medical Necessity Determination ,& renewed determinations:*

Medicaid eligibility must be determined by the provider at the time of an individual's admission to treatment and, in the case of residential treatment, must be reviewed and approved within 24 hours. This requirement will result in an increased need for licensed professional staff in the admissions process for all providers. Decisions counties make about how to provide authorization will impact staff time required to meet these requirements. The demand for qualified staff to engage in medical necessity determinations and the utilization review process will further impact staffing needs and costs.

Other Factors to Consider

- ▶ ***Network adequacy and capacity expansion:***

Rates for DMC–ODS services should take into account not only current or historical operating costs, but also the new demands and requirements under the DMC–ODS waiver or the waiver’s requirements for ASAM competency.

- ▶ ***Same Day Billing:***

It has heretofore been unclear if billing for same–day visits is allowable. However, a new information notice from DHCS will clarify that counties with an approved DMC–ODS Waiver contract will be able to submit DMC claims for the same beneficiary who has received more than one service on the same date, without several of the restrictions currently imposed by state regulation.

Other Factors to Consider

- ▶ ***Intensive Outpatient:***

The DMC-ODS waiver specifies a minimum level of service; however, patients' ASAM assessment may indicate a more intense level of services than the 9 hour per week minimum. Costs should be based on projected/prescribed levels of services rather than the waiver's minimum required services.

- ▶ ***Recovery Services:***

Recovery services to date have not been well defined, and thus cost estimates for the services are not available. A clear definition of recovery services and description of functions is needed in order to estimate the cost of the service.

Other Factors to Consider

- ▶ *Criminal Justice and Non-Criminal Justice Populations: Same level of services.*

The Waiver allows for longer residential treatment stays for eligible beneficiaries with criminal justice backgrounds. However, many patients who may not have current criminal justice cases may have the same need for longer treatment. Since funds other than Medicaid dollars must be used for residential care beyond 90 days, the cost of the extended residential treatment for the beneficiaries without criminal justice backgrounds must be included in any cost estimates.

Other Factors to Consider

▶ *Medication Assisted Treatment (MAT):*

The DMC-ODS requires methadone maintenance services and allows for optional expansion of other Medication Assisted Treatment (MAT) services. In order to expand MAT, which is both needed and a proven evidence based treatment, a better definition and a full range of reimbursement resources is needed in order to bring MAT services into parity with methadone services. MAT services require more than just the medications to be successful and more than standard counseling; they require oversight from medical staff, added support services and case management, administration, dispensing, and more. Costs for the continuum of MAT services need to be calculated and included in any rate structure.

Other Factors to Consider

- ▶ ***Case Management provision:***

Services can be provided at DMC–ODS provider sites, county locations, regional centers, or as outlined by the county in its implementation plan; however, the county will be responsible for determining which entity monitors the case management activities, and should set rates accordingly.

- ▶ ***Physician Consultation:***

Even though this is an optional service, consideration should be given to the costs of physician consultation on treatment plans. Additionally, guidelines are needed for diagnostic testing, laboratory and pharmacy benefits that include how these are accessed and billed.

Other Factors to Consider

- ▶ ***Implementation and continued fidelity to evidence-based programming:***

Quality assurance and clinical supervision are key components of evidence based practices (EBP) sustainability. Staff time required to implement, train, maintain and audit compliance with EBP should be included in any rate setting calculation.

- ▶ ***Administrative compliance with UCLA evaluators:***

The costs of developing and maintaining systems to gather and report data for evaluation should be included in any rate setting calculation.